PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health and Human Services (DHHS)

Health Care Financing Administration (HCFA)

Transmittal No. A-00-36 **Date JUNE 2000**

CHANGE REQUEST 1229

Disregard Program Memorandum (PM) A-00-23, CR 1141, dated April 2000. Substitute this PM, CR 1229, which redlines changes to the original PM.

SUBJECT: Hospital Outpatient Prospective Payment System (OPPS) Implementation Instructions

The purpose of this Program Memorandum (PM) is to provide instructions for implementation of * OPPS, which will be effective for claims with dates of service on or after August 1, 2000. This payment system applies to hospital outpatient departments, community mental health centers (CMHCs) and for limited services, as described in "Background" below, provided by comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs) or to hospice patients for the treatment of a non-terminal illness. It does not apply to critical access hospitals (CAHs), or hospitals in Maryland that are excluded from this system because they qualify under §1814 (b) (3) of the Social Security Act (the Act) for payment under the State's payment system. The excluded services are limited to those paid under the State's payment system as described in §1814 (b) (3) of the Act. In * addition, Indian health service hospitals and hospitals located in Saipan, American Samoa, and Guam will be excluded initially, but will be included under OPPS in the future. Payment under this system will result in discontinuation of the blended payment method for radiology and other diagnostic services and ambulatory surgical center (ASC) services provided in a hospital outpatient department. This PM should be used in conjunction with Transmittal 1787 of the Part A Intermediary Manual (MIM), which contained instructions for reporting HCPCS, units, and line item dates of service, PM A-99-41 and A-00-07 which contain instructions for hospital reporting of modifiers, and PM A-00-21 which contained specifications for the revised outpatient code editor. It supersedes instructions currently contained in §§3626.4, 3627.2, 3627.9 and 3631 of the MIM.

Background

Section 1833 (t) of the Act as added to the Act by §4523 of the Balanced Budget Act (BBA) of 1997, authorizes HCFA to implement a Medicare PPS for:

- Hospital outpatient services, including partial hospitalization services;
- Certain Part B services furnished to hospital inpatients who have no Part A coverage;
- Partial hospitalization services furnished by CMHCs;
- Vaccines, splints, casts and antigens provided by HHAs that provide medical and other health services;
- Vaccines provided by CORFs; and
- Splints, casts, and antigens provided to hospice patients for the treatment of a non-terminal illness.

A proposed regulation discussing HCFA's proposal to implement OPPS was published on September 8, 1998. The proposed rule originally provided for a 60 day comment period, however, the comment period was extended four times and closed on July 30, 1999.

On November 29, 1999 President Clinton signed new legislation which incorporates the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) that contains a number of major provisions that affect the development of the OPPS.

The hospital outpatient provisions of the BBRA provide the following:

- Establish payments under OPPS in a budget neutral manner based on estimates of amounts payable in 1999 from the Part B Trust Fund and as beneficiary coinsurance under the system in effect prior to OPPS. (Although the base rates were calculated using 1999 amounts, these amounts are increased by the hospital inpatient market basket, minus 1 percent, to arrive at the amounts that will be payable in the year 2000.)

- Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs (which had been due to sunset on December 31, 1999) through the first date the OPPS is implemented;

- Require annual updating of the OPPS payment weights, rates, payment adjustments and groups;

- Require annual consultation with an expert provider advisory panel in the review and updating of payment groups;

- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all OPPS services included on the submitted outpatient bill for services furnished before January 1, 2002 and thereafter based on the individual services billed;

- Provide transitional pass-throughs for the additional costs of new and current medical devices, drugs, and biologicals for at least 2 years but not more than 3 years;

- Provide payment under OPPS for implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing;

- Establish transitional payments to limit provider's losses under OPPS; the additional payments are for 3 1/2 years for CMHCs and most hospitals, and permanent for the 10 cancer hospitals; and

- Limit beneficiary coinsurance for an individual service paid under OPPS to the inpatient hospital deductible.

The Secretary has the authority under the §1833 (t) of the Act to determine which services are included (with the exception of ambulance services for which a fee schedule is being separately created). We will continue to pay for clinical diagnostic laboratory services, orthotics, prosthetics, (except as noted above) and for take home surgical dressings on their respective fee schedules, for chronic dialysis using the composite rate, for screening mammographies based on the current payment limitation and for outpatient rehabilitation services (physical therapy including speech language pathology and occupational therapy) under the Medicare Physician Fee Schedule. Acute dialysis, e.g., for poisoning will be paid under OPPS. The 10 cancer centers exempt from inpatient PPS are included in this system, but are eligible for hold harmless payment under the Transitional Corridor provision.

APC Payment Groups

Payment for services under the OPPS is calculated based on grouping outpatient services into ambulatory payment classification (APC) groups. Services within an APC are similar clinically and require similar resource use. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. APCs require no changes to the billing form, however, hospitals are required to include HCPCS codes for all services paid under OPPS. A hospital may require a

number of APC payments for the services furnished to a patient on a single day, however, multiple surgical procedures furnished on the same day are subject to discounting.

Calculation of APC Payment Rates

- A group's relative weight is calculated based on the median cost (operating and capital) of the services included in the group;
- Median costs were developed from a database of CY 96 hospital outpatient claims using "the most recent" cost report data available;
- Used hospital-specific, department-specific cost-to-charge ratios to convert billed charges to median costs for each group;
- Weights are converted to payment rates using a conversion factor which takes into account group weights, the volume of services for each group, and an expenditure target specified in the law; and
- Hospital outpatient payments that would have been effective in CY 99 are calculated, in a budget neutral basis, to equal projected 1999 payments to hospitals for services included under the OPPS.

The rates that will go into effect when OPPS is implemented are the 1999 rates updated by the hospital market basket minus one percent.

Packaging

- Initially, only minimal packaging, i.e., payment for a procedure or medical visit will not include payment for the related ancillary services such as laboratory tests or x-rays;
- Payment for clinical diagnostic laboratory tests which are paid under the clinical diagnostic fee schedule and radiology and other diagnostic services paid under OPPS will be made in addition to the OPPS payment for a surgical procedure or medical visit performed on the same day; and
- APC payments will include certain packaged items, such as anesthesia, supplies, certain drugs and the use of recovery and observation rooms.

Discounting

- Multiple surgical procedures furnished during the same operative session will be discounted;
- The full amount is paid for the surgical procedure with the highest weight; 50 percent is paid for any other surgical procedure(s) performed at the same time;
- Similar discounting occurs now under the physician fee schedule and the payment system for ASCs;
- Surgical procedures terminated after a patient is prepared for surgery but before induction of anesthesia will be paid at 50 percent of the APC payment; and
- When multiple surgical procedures are performed during the same operative session, beneficiary coinsurance is discounted in proportion to the APC payment.

Payment Adjustments

o BBA requires payments to be adjusted to reflect geographic differences in labor-related costs; and

o The Secretary may also establish other adjustments or special adjustments for certain classes of hospitals.

Geographic Adjustment

o Adjustments for differences in wages across geographic areas will be made using inpatient hospital PPS wage index (post-reclassification, post-floor); and

o It is estimated that 60 percent of the group payment represents labor-related costs and will be subject to the geographic adjustment.

Updates

o HCFA will annually review/update groups, relative weights, wage indexes and other adjustments;

o BBA requires rates to be updated annually based on the hospital market basket less one percent for the years 2000 through 2002, and based on the hospital market basket for subsequent years; and

o New outpatient procedures and services will be added to the payment system as needed and weights will be adjusted to reflect changes in outpatient care.

Partial Hospitalization Services

Claims submitted by hospitals and CMHCs for partial hospitalization services must include a mental health diagnosis and indicate for each day of service, the HCPCS and revenue codes that best describe the services furnished. The Outpatient Code Editor (OCE) will determine that, for each day of service appropriate codes are identified and that the services reflect the intensive nature of a partial hospitalization program. For example, the OCE will determine that at least three partial hospitalization HCPCS codes, as indicated in MIM §§3651 and 3661, are included for each day of service, one of which must be a psychotherapy HCPCS code (other than brief psychotherapy). For claims that pass these OCE edits each day of service will be assigned to the partial hospitalization APC and the partial hospitalization per diem amount will be paid. The partial hospitalization APC per diem payment reflects an average day of partial hospitalization. It is expected that most patients on many days will receive more intensive services than reflected in the OCE partial hospitalization edits. Claims that include days that do not pass these edits will be identified for further review.

The total amount payable for psychiatric services furnished in a hospital outpatient department (not under the partial hospitalization program) for an individual for one day will be limited to the APC payment amount for partial hospitalization.

Instruct your hospital outpatient departments to report partial hospitalization services under bill type 13X with condition code 41. This supersedes instructions in §3661of the MIM which currently allows these claims to be billed under bill type 14X .

All Inclusive Rate Hospitals

In order to be paid under OPPS, all-inclusive rate hospitals will be required to HCPCS code the outpatient services they provide and bill charges at the HCPCS level. In addition, they are required to follow bill reporting instructions contained in §442.6 of the hospital manual. Unlike other hospitals, these hospitals do not have outpatient cost-to-charge ratios from prior year cost reports that may be used for purposes of calculating outlier payments, device pass-through payments, or interim transitional corridor payments. As a result, you should use the statewide average urban or rural outpatient cost-to-charge ratio, as appropriate, for all-inclusive rate hospitals. In the future, once cost and charge data for an all-inclusive rate hospital is available, you will be able to apply a cost-to-charge ratio that is specific to the hospital.

* **Hospital-Based Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing for Non RHC/FQHC Services**
*
* Hospitals sometimes operate multi-purpose outpatient facilities based in the hospital, all or part of which may be certified by Medicare as an RHC. Currently these hospital-based facilities/RHCs are permitted to include both RHC and non-RHC services on the same claim, utilizing the RHC bill type (71X). Medicare payment for RHC services is based on an encounter rate payment methodology, while the non-RHC services are typically covered and paid based on current Medicare hospital outpatient methodologies. Implementation of OPPS changes current hospital outpatient payment methodologies and, accordingly, necessitates a change in billing procedures.
*
* Beginning with claims with dates of service on or after August 1, 2000, non-RHC services provided by the aforementioned facilities that were previously paid under hospital outpatient payment methodologies (and that are not currently subject to an existing fee schedule), will be subject to payment under OPPS. As a result, instruct your hospital-based RHCs to discontinue billing non-RHC services on the RHC claim (bill type 71X). When a patient receives non-RHC services from a hospital-based facility certified both as a hospital-based RHC and as part of the hospital outpatient department, the claim for non-RHC hospital outpatient services must be submitted utilizing the hospital bill type (13Xor 14X) along with the hospital's provider number, since the services are not covered as RHC services but instead may be covered hospital outpatient and paid under either hospital OPPS or existing fee schedules.
*
* This change in billing is needed to assure proper payment under OPPS. RHC services remain subject to the encounter rate payment methodology and will continue to be billed using the RHC provider number, RHC bill type (71X) and revenue codes 52X and 91X.
*
* The policies described above also apply to hospital based FQHCs. However, hospital-based FQHCs currently submit separate bills for their FQHC and non-FQHC services as described in §3643G of the Medicare Intermediary Manual.
*
* Covered RHC/FQHC services include physician and nonphysician services and any services or supplies incident to such services. See §400 of the Medicare RHC/FQHC manual or Federal regulations at §405.2411 for additional information concerning RHC/FQHC services.
*
* **Hospital-Based End Stage Renal Dialysis (ESRD) Facility Billing**
*
* Effective with claims with dates of service on or after August 1, 2000, instruct your hospital-based ESRD facilities, that are not already doing so, to submit ESRD dialysis and those items and services directly related to the dialysis (e.g., drugs, supplies) on a separate claim from non-related ESRD dialysis services. Items and services not related to the dialysis are required to be billed by the hospital using the hospital bill type. This requirement is necessary to properly pay the non-related ESRD services under OPPS.

Coding for Clinic and Emergency Visits

Formerly hospitals could report CPT code 99201 to indicate a visit of any type. Under OPPS, 31 codes are used to indicate visits, with payment differentials for more or less intense services. Hospitals should code the site of the visit and the level of intensity, using the following codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, G0101, and G0175. Because CPT is more descriptive of practitioner than of facility services, hospitals should use CPT guidelines when applicable, or crosswalk hospital coding structures to CPT. For example, a hospital that has 8 levels of emergency and trauma care, depending on nursing ratios, should walk those 8 levels to the CPT codes for emergency care.

HCPCS/Revenue Code Chart

The following chart reflects HCPCS coding required to be reported under OPPS by hospital outpatient departments. This chart supersedes coding instructions and edit requirements for outpatient surgery, diagnostic and medical services and radiology services represented in §§3626.4, 3627.9 and 3631 of the MIM. **It is intended only as a guide to be used by hospitals to assist them in reporting services rendered. Hospitals that are currently utilizing different revenue/HCPCS reporting may continue to do so. They are not required to change the way they currently report their services to agree with this chart. Note that this chart does not represent all HCPCS coding subject to OPPS but will be expanded at a later date.**

Revenue Code	HCPCS Code	Description
*	10040-69990	Surgical Procedure
*	92950-92961	Cardiovascular
*	96570, 96571	Photodynamic Therapy
*	99170, 99185, 99186	Other Services and Procedures
*	99291-99292	Critical Care
*	99440	Newborn Care
*	90782-90799	Therapeutic or Diagnostic Injections
*	D0150, D0240-D0274, D0277, D0460, D0472-D0999, D1510-D1550, D2970, D2999, D3460, D3999, D4260-D4264, D4270-D4273, D4355-D4381, D5911-D5912, D5983-D5985, D5987, D6920, D7110-D7260, D7291, D7940, D9630, D9930, D9940, D9950-D9952	Dental Services
*	92502-92596, 92599	Otorhinolaryngologic Services (ENT)
278	E0749, E0782, E0783, E0785	Implanted Durable Medical Equipment
278	E0751, E0753, L8600, L8603, L8610, L8612, L8614, L8619, L8630, L8641, L8642, L8658, L8670, L8699	Implanted Prosthetic Devices
302	86485-86586	Immunology
305	85060-85102, 86077-86079	Hematology
Revenue Code	**HCPCS Code**	**Description**
31X	80500-80502	Pathology - Lab

310	88300-88365, 88399	Surgical Pathology
311	88104-88125, 88160-88199	Cytopathology
* 32X	70010-76092, 76094-70999	Diagnostic Radiology
333	77261-77799	Radiation Oncology
34X	78000-79999	Nuclear Medicine
37X	99141-99142	Anesthesia
413	99183	Other Services and Procedures
45X	99281-99285	Emergency
46X	94010-94799	Pulmonary Function
480	93600-93790, 93799, G0166	Intra Electrophysiological Procedures and Other Vascular Studies
481	93501-93571	Cardiac Catheterization
482	93015-93024	Stress Test
483	93303-93350	Echocardiography
5lX	92002-92499	Ophthalmological Services
51X	99201, 99215, 99241-99245, 99271-99275	Clinic Visit
* 510, 517, 519 *	95144-95149, 95165, 95170, 95180, 95199	Allergen Immunotherapy
519	95805-95811	Sleep Testing
530	98925-98929	Osteopathic Manipulative Procedures
636	A4642, A9500, A9605	Radionclides
636	90296-90379, 90385, 90389-90396	Immune Globulins
636	90476-90665, 90675-90749	Vaccines, Toxoids
73X	G0004-G0006, G0015	Event Recording ECG
Revenue Code	**HCPCS Code**	**Description**
730	93005-93014, 93040-93224, 93278	Electrocardiograms (ECGs)
731	93225-93272	Holter Monitor

* 74X	95812-95827, 95950-95962	Electroencephalogram (EEG)
771	G0008-G0010	Vaccine Administration
88X	90935-90999	Non-ESRD Dialysis
901	90870,90871	Psychiatry
903	90910, 90911, 90812-90815, 90823, 90824, 90826-90829	Psychiatry
909	90880	Psychiatry
910	90801, 90802, 90865, 90899	Psychiatry
914	90804-90809, 90816-90819, 90821, 90822, 90845, 90862	Psychiatry
915	90853, 90857	Psychiatry
916	90846, 90847, 90849	Psychiatry
917	90901-90911	Biofeedback
918	96100- 96117	Central Nervous System Assessments / Tests
92X	95829-95857, 95900-95937, 95970-95999	Miscellaneous Neurological Procedures
920, 929	93875-93990	Non Invasive Vascular Diagnosis Studies
922	95858-95875	Electromyography (EMG)
924	95004-95078	Allergy Test
940	96900-96999	Special Dermatological Procedures
940	98940-98942	Chiropractic Manipulative Treatment
940	99195	Other Services and Procedures
943	93797-93798	Cardiac Rehabilitation

*Revenue codes have not been identified for these procedures, as they can be performed in a number of revenue centers within a hospital, such as emergency room (450), operating room (360), or clinic (510). Instruct your hospitals to report these HCPCS codes under the revenue center where they were performed.

NOTE: The listing of HCPCS codes contained in the above chart does not assure coverage of the specific service. Current coverage criteria apply.

* Do not install additional edits for the matching of revenue and HCPCS codes.

New HCPCS Coding Requirements

As stated in the background section above, payments will be made under OPPS:

- To CORFs (bill type 75X) for vaccines;
- To HHAs (bill type 34X) for splints, casts, vaccines and antigens when provided as a medical and other health service; and
- For splints, casts and antigens when provided to hospice patients for treatment of a non-terminal illness by other than a hospital outpatient department. This requires reporting of condition code 07.

As a result, instruct your CORFs, HHAs, and other providers to report HCPCS for these services, in order to assure payment under this system. Payment will continue to be made for vaccines provided to hospice patients by the Medicare Part B carrier. The appropriate HCPCS codes are as follows:

	Antigens	95144 - 95149, 95165, 95170, 95180 and 95199
*	Vaccines	90657 - 90659, 90732, 90744, 90746, 90747, 90748, G0008, G0009, and G0010
	Splints	29105-29131, 29505-29515
*	Casts	29000-29085, 29305, 29325-29445, 29450, 29700-29750, 29799

NOTE: Advise your HHAs to report the above HCPCS codes with the exception of vaccines under * Revenue Code 550 (Skilled Nursing). The only time revenue code 550 may be reported is * when the HHA is billing for antigens, splints, or casts. See §3660.7 of the MIM for the * reporting of vaccines by HCPCS codes.

Deductible Application

PRICER applies deductible to OPPS services on a claim and you apply the deductible to other types of services subject to other payment methods on the same claim. PRICER will automatically apply deductible to the APC line item with the largest national unadjusted coinsurance as a percent of the APC payment and then to the next largest coinsurance as a percent of the APC payment and so on until the deductible is met or no other payments can be used to satisfy the deductible. This method of applying the deductible is the most advantageous for the beneficiary. If less than $100 or less than the beneficiary's remaining deductible amount is applied, the total deductible applied to the OPPS claim must be added to any applicable deductible for any other types of payments on the same claim and then be submitted to CWF. If the amount submitted to CWF is under or over applied, the claim must be repriced by the PRICER software.

Deductible does not apply to the influenza virus vaccines, pneumococcal pneumonia vaccine, clinical diagnostic laboratory services (which includes screening pap smears), screening mammographies, screening pelvic examinations, and screening prostate examinations. Only influenza virus vaccine, * pneumococcal pneumonia vaccine, screening pelvic examinations and screening prostate * examinations are subject to OPPS.

Coinsurance

Under current law, coinsurance for hospital outpatient and CMHC services is based on 20 percent of the hospital's or CMHC's billed charges. OPPS freezes coinsurance at 20 percent of the national median charge for the services within each APC (wage adjusted for the provider's geographic area) but coinsurance for an APC cannot be less than 20 percent of the APC payment rate. As the total payment to the provider increases each year based on market basket updates, the present or *frozen* coinsurance amount will become a smaller portion of the total payment, until coinsurance represents 20 percent of the total payment. Once coinsurance becomes 20 percent of the payment amount, the

annual updates will also increase coinsurance so that it continues to account for 20 percent of the total payment. As previously stated, the wage-adjusted coinsurance for a service under OPPS cannot exceed the inpatient deductible amount.

For screening colonoscopies and sigmoidoscopies, the coinsurance amount is 25 percent of the payment rate. The APC payment rate is limited to the lower of the hospital outpatient rate or the ASC payment rate. The payment rate for screening barium enemas is the same as that for diagnostic barium enemas. The coinsurance amount for screening barium enemas is 20 percent of the APC payment rate.

Coinsurance does not apply to influenza virus vaccines, pneumococcal pneumonia vaccines and clinical diagnostic laboratory services (which includes screening pap smears and screening prostate specific antigen testing).

See coinsurance calculations below for more detail.

Coinsurance Election

The transition to the standard Medicare coinsurance rate (20 percent of the APC payment rate) will be gradual. For those APC groups for which coinsurance is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. The law offers hospitals the option of electing to reduce coinsurance amounts and advertise their reduced rates for all OPPS services. They may elect to receive a coinsurance payment from Medicare beneficiaries that is less than the
* wage adjusted coinsurance amount per APC and that amount will apply to all services within that APC. This coinsurance reduction must be offered to all Medicare beneficiaries. They should review the list of APCs and their respective coinsurance amounts that is published in the ***Federal Register*** as a final rule. After adjusting those coinsurance amounts for the wage index applicable to their MSA, they must notify their intermediary if they wish to charge their Medicare beneficiaries a lessor amount
* until the following calendar year. The first election must be filed by July 1, 2000, for the period
* August 1, 2000 through December 31, 2000. Future calendar year elections must be made by December 1st of the year preceding the calendar year for which the election is being made. The lessor amount elected may not be less than 20 percent of the wage adjusted APC payment amount. The lessor amount elected may not be greater than the inpatient hospital deductible for that calendar year ($776 for 2000). The lessor amount elected will not be wage adjusted by you or HCFA. Once an election to reduce coinsurance is made, it cannot be rescinded or changed until the next calendar year. National unadjusted and minimum unadjusted coinsurance amounts will be posted in the addenda of the OPPS final rule (HCFA-1005FC) on HCFA's web site (www.hcfa.gov).

This coinsurance election does not apply to partial hospitalization services furnished by CHMCs, vaccines provided by a CORF, vaccines, splints, casts and antigens provided by HHAs or splints, casts, and antigens provided to a hospice patient for the treatment of a non-terminal illness. It also does not apply to screening colonoscopies, screening sigmoidoscopies, or screening barium enemas,
* or to services not paid under OPPS.

Advise hospitals to utilize the following format for notification to you:

Provider number 876543
* Provider name XYZ Hospital Effective from 8/1/2000 - 12/31/2000
Provider contact Joe Smith Phone # 123-456-7890 x123
Contact E Mail jsmith@XYZ.ORG Fax # 123-456-7891

XYZ Hospital elects to reduce coinsurance to the amount shown for the following APCs:

APC____	Coinsurance___.__	APC____	Coinsurance___.__
APC____	Coinsurance___.__	APC____	Coinsurance___.__
APC____	Coinsurance___.__	APC____	Coinsurance___.__
APC____	Coinsurance___.__	APC____	Coinsurance___.__
APC____	Coinsurance___.__	APC____	Coinsurance___.__
APC____	Coinsurance___.__	APC____	Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__

Return to:
Provider Audit & Reimbursement Dept.
Attn: John Doe
Intermediary Address

You must send an acknowledgment to the hospital that their election has been received within 15 calendar days of receipt. The reduced coinsurance amount, elected by the hospital, must be validated to ensure it is not less than 20 percent of the wage adjusted APC amount nor more than the inpatient deductible for the year of the election.

Calculating the Medicare Payment Amount and Coinsurance

A program payment percentage is calculated for each APC by subtracting the unadjusted national coinsurance amount for the APC from the unadjusted payment rate and dividing the result by the unadjusted payment rate. The payment rate for each APC group is the basis for determining the total payment (subject to wage-index adjustment) a hospital will receive from the beneficiary and the Medicare program. (A hospital that elects to reduce coinsurance, as described in "Coinsurance Election" above, may receive a total payment that is less than the APC payment rate.) The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. In addition, the amount calculated for an APC group applies to all the services that are classified within that APC group. The Medicare payment amount for a specific service classified within an APC group under OPPS is calculated as follows:

Step 1 Apply the appropriate wage index adjustment to the payment rate that is set annually for each APC group;

Step 2 Subtract from the adjusted APC payment rate the amount of any applicable deductible;

Step 3 Multiply the adjusted APC payment rate, from which the applicable deductible has been subtracted, by the program payment percentage determined for the APC group or 80 percent, whichever is lower. This amount is the preliminary Medicare payment amount;

Step 4 Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less the amount of any applicable deductible. If the resulting amount does not exceed the annual hospital inpatient deductible amount for the calendar year, the resulting amount is the beneficiary coinsurance amount. If the resulting amount exceeds the annual inpatient hospital deductible amount, the beneficiary coinsurance amount is limited to the inpatient hospital deductible and the Medicare program pays the difference to the provider;

Step 5 If the wage-index adjusted coinsurance amount for the APC is reduced because it exceeds the inpatient deductible amount for the calendar year, add the amount of this reduction to the amount determined in Step 3 above to get the final Medicare payment amount.

Example 1

The wage-adjusted payment rate for an APC is $300; the program payment percentage for the APC group is 70 percent; the wage-adjusted coinsurance amount for the APC group is $90; and the beneficiary has not yet satisfied any portion of his or her $100 annual Part B deductible.

(A) Adjusted APC payment rate: $300.

(B) Subtract the applicable deductible: $300 - $100 = $200.

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount: 0.7 x $200 = $140.

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less any unmet deductible to determine the coinsurance amount, which cannot exceed the inpatient hospital deductible for the calendar year: $200 - $140 = $60.

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation. $140 + $0 = $140.

In this case, the beneficiary pays a deductible of $100 and a $60 coinsurance, and the program pays $140, for a total payment to the provider of $300. Applying the program payment percentage ensures that the program and the beneficiary pay the same proportion of payment that they would have paid if no deductible were taken.

If the annual Part B deductible has already been satisfied, the calculation is as follows:

(A) Adjusted APC payment rate: $300.

(B) Subtract the applicable deductible: $300 - 0 = $300.

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount: 0.7 x $300 = $210.

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the amount of the inpatient hospital deductible for the calendar year: $300 - $210 = $90.

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation: $210 + $0 = $210.

In this case, the beneficiary makes a $90 coinsurance payment and the program pays $210, for a total payment to the provider of $300.

Example 2

This example illustrates a case in which the inpatient hospital deductible limit on coinsurance amount applies. Assume that the wage-adjusted payment rate for an APC is $2,000; the wage-adjusted coinsurance amount for the APC is $900; the program payment percentage is 55 percent; the inpatient hospital deductible amount for the calendar year is $776 and the beneficiary has not yet satisfied any portion of his or her $100 Part B deductible.

(A) Adjusted APC payment rate: $2,000.

(B) Subtract the applicable deductible: $2,000 - $100 = $1,900.

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount: 0.55 x $1,900 = $1,045.

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the inpatient hospital deductible amount of $776: $1,900 - $1,045 = $855, but the coinsurance is limited to $776.

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation ($855 - $776 = $79). $1,045 + $79 = $1,124.

In this case, the beneficiary pays a deductible of $100 and a coinsurance that is limited to $776 and the program pays $1,124 (which includes the amount of the reduction in beneficiary coinsurance due to the inpatient hospital deductible limitation) for a total payment to the provider of $2,000.

Outpatient Provider Specific File

The outpatient provider (OPROV) specific file is variable length with a minimum size of 100 positions and contains the required information about each provider to enable the pricing software to calculate the payment amount. Maintain the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, prepare an additional record showing the effective date. For example, when a provider's FY beginning date changes as a result of a change in ownership or other "good cause," make an additional record showing the effective date of the change.

The format and data shown below are required by the outpatient PRICER program and by the outpatient provider specific file you submit every 3 months.

File Position	Format	Title
* 1-8	X(8)	National Provider Identifier (NPI) (For future use.)
9-10	X(2)	NPI Filler
11-16	X(6)	Provider Oscar Number
17-24	9(8)	Effective Date
25-32	9(8)	Fiscal Year Beginning Date
33-40	9(8)	Report Date
41-48	9(8)	Termination Date
49	X	Waiver Indicator
50-54	9(5)	Intermediary Number
55-56	X(2)	Provider Type
57	X	Filler
58	X	Change Code for Wage Index Reclassification

File Position	Format	Title
59-62	X(4)	Actual Geographic Location--MSA
63-66	X(4)	Wage Index Location--MSA
67-70	9V9(3)	Cost of Living Adjustment
71-75	9(5)	Bed Size
76-79	9V9(3)	Outpatient Cost to Charge Ratio - **NEW**
80-96	X(17)	Filler
97-100	9(4)	Reduced Coinsurance Trailer Count - **NEW**

* Enter the number of APCs the provider has elected to reduce coinsurance for. Cannot be greater than 999.

* Reduced Coinsurance Trailer -- Occurs 0 to 999 times depending on the Reduced Coinsurance Trailer Count in positions 97-100. Due to systems capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

9(4) APC Classification - **NEW**
Enter the four digit APC classification the provider has elected to reduce coinsurance for.
9(4)V9(2) Reduced Coinsurance Amount - **NEW**
Enter the reduced coinsurance amount elected by the provider.

* The Standard System will verify that the last position on this record is equal to the number in positions
* 97 through 100 times (10) plus 100.

OPPS PRICER

Outpatient PRICER determines the amount to pay as well as deductions for deductible and coinsurance.

This HCFA developed software determines the APC line item price based on data from the OPROV specific file, your beneficiary deductible record and the OCE output file. The software will output a data record with the following information:

- o All information passed from OCE;
- o The APC line item payment amount;
- o The APC line item deductible;
- o The APC line item coinsurance amount;
- o The total deductible applied to the OPPS services on the claim;
- o The total outlier amount for the claim to be paid in addition to line item APC payments and to be output to CWF via value code 17 same as the current process for inpatient outlier payments;
- o The partial hospitalization payment amount if applicable; and
- o A PRICER assigned review code to indicate why/how PRICER rejected or paid the claim.

See your PRICER implementation guide for information concerning PRICER processing reports, input parameters, and data requirements.

Transitional Pass-Throughs for Designated Drugs or Biologicals

Certain current designated drugs and biologicals will be assigned to special APCs and identified by
* the OCE as eligible for payment at 95 percent of the average wholesale price minus the portion of the
* otherwise applicable APC payment amount. PRICER will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated drug and biological. Certain new designated drugs and biologicals may be approved for payment and their payment will be calculated in the same manner as listed above for current designated drugs and biologicals. These new designated drugs and biologicals will be identified separately from the current designated drugs and biologicals.

Transitional Pass-Throughs for Designated Devices

Certain designated new devices will be assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects payment for the old device. PRICER will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device.

Outlier Adjustments

PRICER will calculate outlier payments on a claim by claim basis. The outlier payment will be calculated by:

- o Calculating the costs related to the OPPS services on the claim by multiplying the total charges for covered OPPS services by an outpatient cost to charge ratio;
- o Determining whether these costs exceed 2.5 times the OPPS payments (APC payments plus any transitional pass-through amounts for drugs, biologicals and/or devices) for the claim; and

o If costs exceed 2.5 times the OPPS payments, the outlier payment is calculated as 75 percent
* of the amount by which the costs exceed 2.5 times the OPPS payments.

The result will be output from PRICER for the standard system to capture and store as value code 17
* (outlier amounts), which is currently used to identify inpatient hospital outliers.

Transitional Corridor Payments

* Beginning September 1, 2000, and every month thereafter until further notice, the standard system maintainers must provide intermediaries with software that gathers all data required to calculate a transitional outpatient payment (TOP) amount for each hospital and CMHC. The software must
* calculate and pay the TOP amount for OPPS services on claims processed during the preceding month, maintain an audit trail (including the ability to generate a hardcopy report) of these TOP amounts, and
* transfer to the PS&R system any necessary data. TOP amounts should be paid before the next month begins and are not subject to normal payment floor requirements.

Eight items contained in the provider file and defined under the OPROV Specific File section above are needed to calculate the TOP amount for each hospital or CMHC. They are the provider number, fiscal year begin date, the provider type, change code for wage index reclassification, actual geographic location--MSA, wage index location--MSA, bed size and outpatient cost to charge ratio. One additional item will be output from the PRICER software in 9(7)V99 format. It is the outlier payment amount. The standard system will sum the following items for use in steps 1 & 2 below: total charges for all covered OPPS services on the claim, total OPPS Medicare program payments on the claim, total unreduced OPPS coinsurance on the claim and total OPPS deductible on the claim.

The TOP amount is calculated as follows:

Step 1 Find the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost to charge ratio, and multiply this amount by a payment to cost ratio of .8.

Step 2 Find the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month under OPPS. If the result is greater than the result of step 1, go to step 9. No transitional payment is due this month.

* **Step 3** If the hospital is a small rural hospital with not more than 100 beds or a cancer hospital go to step 4 only. If any other type of hospital, divide the result of step 2 by the result of step 1, skip step 4 and perform step 5, 6, 7, or 8 as appropriate.

* **Step 4** If the hospital is a small rural hospital with not more than 100 beds or a cancer hospital subtract the result of step 2 from the result of step 1 and pay .85 times this amount. Do not perform steps 5-8.

Step 5 If the result of step 3 is greater than or equal to .9 and less than 1.0, subtract the result of step 2 from the result of step 1 and multiply the difference by .8 and pay .85 times this amount.

Step 6 If the result of step 3 is greater than or equal to .8 and less than .9, subtract .7 times the result of step 2 from .71 times the result of step 1 and pay .85 times this amount.

Step 7 If the result of step 3 is greater than or equal to .7 and less than .8, subtract .6 times the result of step 2 from .63 times the result of step 1 and pay .85 times this amount.

Step 8 If the result of step 3 is less than .7, multiply the result of step 1 by .21 and pay .85 times this amount.

Step 9 When the result of step 2 is greater than the result of step 1 for the final month of a providers cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for

any other month, store all step 1 and step 2 totals and include these totals with the totals for the next months TOP calculation.

Corneal Tissue

Corneal tissue will be paid on a cost basis, not under OPPS. To receive cost based reimbursement
* advise your hospitals to bill charges for corneal tissue using HCPCS code V2785.

* **Billing for Drugs and Biologicals**
*
* Most drugs are packaged under OPPS. Their costs are recognized and captured but paid as part of
* the service with which they were billed in the base year, 1996. Certain drugs, however, are paid
* separately. These include chemotherapeutic agents and the supportive and adjunctive drugs used with
* them, immunosuppressive drugs, orphan drugs, radiopharmaceuticals, and certain other drugs such as
* those given in the emergency room for heart attacks. These drugs and the codes used to bill for them
* are listed in Addendum B of the Final Rule and on the HCFA Web site, hcfa.gov. The classes of drugs
* required to have "pass through" payments made under BBRA (chemotherapeutic agents and the
* supportive and adjunctive drugs used with them, immunosuppressive drugs, orphan drugs,
* radiopharmaceuticals, and some new drugs) have coinsurance amounts that can be less than 20 percent
* of the Average Wholesale Price (AWP). This is because pass-through amounts, by law, are not
* subject to coinsurance. We consider the amount of the payment rate that exceeds the estimated
* acquisition cost of the drug to be the pass-through amount. Thus, the coinsurance is based on a portion
* of the payment rate, not the full payment rate.
*
* Drugs should be billed in multiples of the dosage, rounded up, associated with the covered code.

Appropriate Bill Types

The following bill types are subject to OPPS:

o All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41, 13X without condition code 41 or 14X) with the exception of bills from hospitals in Maryland, Indian
* health service, CAHs, and hospitals located in Saipan, American Samoa, and Guam;

o CMHC bills (bill type 76X);

o CORF and HHA bills containing certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above (bill types 75X or 34X); and

o Any bill containing a condition code 07 with certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above.

NOTE: For bill type 34X only vaccines and their administration, splints, casts, and antigens will be paid under OPPS. For bill type 75X only vaccines and their administration will be paid under OPPS. For bills containing condition code 07 only splints, casts, and antigens will be paid under OPPS.

Discontinuation of Bill Type 83X for Hospitals Subject to OPPS

Since bill type 83X "Ambulatory Surgical Center Services to Hospital Outpatients" will not be utilized under OPPS, hospitals are required, beginning with claims with dates of service on or after
* August 1, 2000, to report in Form Locator 6 "Statement Covers Period From Date" the earliest date

services were rendered. As a result, pre-operative laboratory services will always have a line item date of service within the from and through dates on the claim. The instructions in §3626.4 of the MIM only apply to claims with dates of service prior to August 1, 2000.

Indian health service hospitals continue to bill for surgeries utilizing bill type 83X.

Discontinuation of Value Code 05 Reporting

With line item date of service reporting, there will be no way to correctly allocate professional component charges reported in value code 05 to specific line items on the claim. As a result, advise your hospitals that currently report professional component charges in value code 05 on outpatient claims to no longer include the professional component amount in their charges and to discontinue reporting the professional component in value code 05.

Provider Reporting Requirements

Advise your providers paid under OPPS not to include July 2000 and August 2000 dates of service on the same claim. Standard systems must edit to assure that a hospital or CMHC claim does not contain dates of service that span July 2000 and August 2000. In addition, advise your hospitals and CMHCs that every effort should be made to report all services performed on the same day on the same claim to assure proper payment under OPPS. Return claims submitted for the same date of service to the provider (except duplicates or those containing condition codes 20, 21 or G0) with a notification that an adjustment bill should be submitted. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

Procedures for Submitting Late Charges

Hospitals and CMHCs may not submit a late charge bill (Step 5 in the third position of the bill type) for bill types 12X, 13X, 14X, and 76X effective for claims with dates of service on or after August 1, 2000. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units and line item dates of service by reporting a 7 in the third position of the bill type. Separate bills containing only late charges will not be permitted.

The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing by OCE and payment under OPPS.

Subject adjustment claims to the same edits that you apply to initial claims.

Instructions in §3603.B of the MIM regarding monthly billing of repetitive services still apply.

Proper Reporting of Surgical Procedures

The current procedures outlined in §3626.4B3 of the MIM apply under OPPS.

Proper Reporting of Condition Code G0 (Zero)

Hospitals report Condition Code G0 on FLs 24-30 (or the corresponding electronic location) when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.

Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code GO on the second claim.

Proper reporting of Condition Code G0 allows for proper payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.

* To further illustrate, the following table describes actions the OCE will take when multiple medical
* visits occur on the same day in the same revenue code center:
*

Evaluation and Management (E&M)	Revenue Center	Condition Code	OCE Action
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue center	G0	Assign medical APC to each line item with E&M code

Proper Reporting of Condition Codes 20 and 21

Hospitals and CMHCs may report condition codes 20 and 21 when they realize the services are excluded from coverage but:

- The beneficiary has requested a formal determination (condition code 20); or
- The provider is requesting a denial notice from Medicare to bill Medicaid or other insurers (condition code 21).

Advise your hospitals and CMHCs when billing condition codes 20 and 21 a separate claim must be submitted. Covered and non-covered services should not be reported on the same claim.

Implanted DME, Prosthetic Devices and Diagnostic Devices

Implanted DME, implanted prosthetic devices, and implanted diagnostic devices are paid under OPPS and therefore are no longer payable under the DME/Prosthetic fee schedules. The following are the appropriate HCPCS codes for payment under OPPS.

Implanted DME: E0749, E0782 ,E0783, E0785
Implanted Prosthetic Devices: E0751, E0753, L8600, L8603, L8610, L8612, L8613, L8614, L8630, L8641, L8642, L8658, L8670, L8699
* Implanted Diagnostic Device: C1361

* Advise your hospitals effective with claims with dates of service on or after August 1, 2000 to discontinue billing the local carrier for these services.

This supersedes instructions in §3629A of the MIM regarding implanted devices.

Clinical Diagnostic Laboratory Services Furnished to Inpatients Under Part B

Payment for clinical diagnostic laboratory services furnished under the inpatient Part B benefit (bill type 12X) which are currently reimbursed on cost will not be paid under OPPS. Therefore, make payment for these services under the clinical diagnostic laboratory fee schedule. This supersedes instructions in §3628B of the MIM which requires payment based on a reasonable cost basis.

Advise your hospitals to report HCPCS codes for clinical diagnostic laboratory services.

Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB)

* As a result of implementation of OPPS, effective for claims with dates of service on or after August 1, 2000, the MSN must be modified to reflect the addition of an APC number. This APC number should be reflected next to the HCPCS code included under the "Services Provided" column, and must be within a parenthesis. The coinsurance column should reflect the coinsurance amount that the beneficiary is responsible for.

If you are still issuing the Part A EOMB, you must modify the EOMB to only reflect the coinsurance amount. Any reference to the 20 percent coinsurance calculation should be removed, as coinsurance is no longer being calculated based on 20 percent of charges.

In addition, the back of both notices must be modified. In place of the current language and to be consistent, the notices should reflect the following language:

THE AMOUNT YOU MAY BE BILLED for **Part B** services includes:

- **An annual deductible**, the first $100 of Medicare Part B charges each year;

* - After the deductible has been met for the year, depending on services received, a
* **coinsurance amount** (20 percent of the amount charged), or a fixed **copayment** for each service; and

- Charges for services or supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a note on the front will tell you.

The Spanish version for intermediaries issuing the MSN should read as follows:

La cantidad por la cual usted podría ser facturado incluye:

- **Un deducible anual**, los primeros $100 de Medicare Parte B de cargos aprobados cada año,

* - Depués de que haya cumplido con el deductible, dependiendo de los servicios recibidos,
* **un coaseguro** (20% de la cantidad cobrada), o un **copago fijo** por cada servcio,

- Cargos por servicios/suministros que **no están cubiertos** por Medicare. Es posible que usted no tenga que pagar por ciertos cargos se servicios denegados. De ser el caso, una NOTA en la parte del frente le indicará.

NOTE: Continue to print all other HCFA mandated language on the back of the notice.

* Also, print the following message in the General Information Section:
*
* If the coinsurance amount you paid is more than the amount shown on your notice, you are entitled to
* a refund. Please contact your provider.
*
* Spanish Version:
*
* Si la cantidad de coaseguro que usted pagó es mayor que la cantidad que muestra su notificación, tiene
* derecho a un reembolso. Por favor comuníquese con su proveedor.

Standard Paper and Electronic Remittance Advice Changes

Attachment 1 contains the 2000 version of the Standard Paper Remittance (SPR) Advice. This attachment must be read and printed in landscape. Due to the number of data elements in an SPR, an SPR must be printed and read across, rather than down, a page. If printed in a portrait format, the data in the columns to the far right will scroll to the next line, making an SPR almost illegible. This version will supplant the earlier SPR effective with implementation of OPPS. The following SPR changes are included in this version:

o The reference to HCPCS changed to "procedure code" as other code sets such as the National Drug Code (NDC) may begin to be used in addition to HCPCS in the future.

o The DRG operating amount and the DRG capital amount will no longer be reported separately. A combined DRG operating and capital amount will now be reported in the SPR to correspond to reporting of this information in the 835.

o A summary data element has been added for the TOP, a monthly provider payment which will be issued as warranted to supplement line item payments for services paid under OPPS.

o Date fields in the SPR have been expanded to enable reporting of the century. Some, but not all, SPR dates previously accommodated century reporting.

o Although previously implemented, the hemophilia add on has been added to the format document.

NOTE: Only the third bullet above is directly related to OPPS, but the remaining information must be included to reflect incremental modifications to the SPR.

As with inpatient PPS, only summary data will be reported in the SPR for OPPS. The standard systems maintainers will report detailed service line data only in version 3051.4A.01 and later 835 electronic remittance advice transactions. The Fiscal Intermediary Shared System (FISS) will continue to report claim level summary data without service line information in the version 3030M and 3051.3A 835 transactions. Providers on FISS who wish to receive service line level data must upgrade to the 835 version 3051.4A.01 transaction format.

Attachment 2 contains field characteristics for the 2000 version of the SPR and mapping information between the SPR and the 835. The FISS maintainer must expand the flat files for the supported 835 versions at the claim or line levels as appropriate to include OPPS-specific data elements (described below), and furnish relevant mapping information between those data elements and the SPR and the supported versions of the 835 (see FISS mapping-required notations in the attachment 4 implementation guide replacement pages).

Electronic remittance advice format requirements:

o Substitute the replacement pages in Attachment 3 in your hard copy version 3051.4A.01 implementation guide. These changes are also being added to version 3051.4A.01 at www.hcfa.gov/medicare/edi/edi.htm, and include:

- 2-062-AMT02 modified to allow reporting of either inpatient or partial hospitalization per diem.

NOTE: Make the same "pen and ink" change to the corresponding pages in the version 3030M and 3051.3A implementation guides. This is a claim level segment which will also need to be reported in those versions. (Since those versions were established in obsolete software which is no longer supported, replacement pages cannot be attached to this instruction for those versions.)

Also report the amount of any outlier PRICER determines payable for the claim in a separate AMT loop with ZZ in AMT01 and the outlier amount in AMT02.

- 2-100.A-REF and REF02 modified to allow service line reporting of the APC and the
* Health Insurance Prospective Payment System (HIPPS) code. The APC will supplant the Ambulatory
* Surgical Center (ASC) group upon implementation of OPPS. PRICER supplies an APC only for a
* single HCPCS included in that APC, and not for any additional HCPCS included in an APC.

- 2-100.B-REF modified to allow service line reporting of the home health payment percentage, when effective. This segment applies to ASC and Home Health PPS, but does not apply to APC payments.

- 2-110.A-AMT modified to allow service line reporting of the allowed amount for APC and home health HIPPS payments.

- The standard provider level adjustment reason codes in Appendix B have been expanded to include the X12 835 code of BN (bonus) for the reporting of transitional OPPS payments. Make the same "pen and ink" change to the corresponding pages in the version 3030M and 3051.3A implementation guides. This is a claim level segment and will need to be reported in those versions. (Since those versions were established in obsolete software which is no longer supported, replacement pages cannot be attached to this instruction for those versions.)

o Treat the amount determined payable for an OPPS service, whether APC, AWP, etc., as the allowed amount for a service in version 3051.4A.01. The type of bill in CLP08 identifies whether a service is an outpatient hospital, CMHC, HHA or other category of intermediary processed claim. In multiple payment option situations, Medicare routinely uses the highest rate permitted by law to determine payment. A remittance advice does not typically identify which of the possible cost bases is being used for payment.

o Report services that do not have a related APC, and which are considered to be included in the payment for one or more other APCs, with Group Code CO and reason code 97 (payment included in the allowance for another service/procedure) in version 3051.4A.01. If a non-APC service on the same claim is denied for another reason, such as not reasonable or necessary (CO 50), report the specific reason code that applies to that denial rather than CO 97.

o Use the 835 version 3051.4A.01 bundling methodology to report APC payment when multiple HCPCS are included in a single APC. When bundling services into an APC grouping, report service line information back to a provider in the same way as billed, so the provider may automatically identify the services involved and post payment information to patient accounts.

o Report each procedure billed in a version 3051.4A.01 remittance advice, even if bundled for payment into a single APC. However, report the payment for all of the services in a single APC on the line for the first listed service in that APC. Since the payment for the entire APC will be higher than for that procedure code alone, you must enter group code OA (other adjustment) and reason code 94 (processed in excess of charges) for the amount of the excess (difference between the billed amount for the service and the allowed rate for the APC) as a negative amount to enable the line and claim
* to balance. Report the remaining procedures for that APC on subsequent lines of the remittance advice with group code CO and reason code 97 (payment included in the allowance for another service/procedure) for each. Repeat the process if there are multiple APCs for the same claim.

The FISS maintainer must make changes to the PC-Print software to correspond to these changes to Medicare's version 3051.4A.01 835 implementation guide and to the Medicare SPR. The maintainer must make the revised PC-Print software available to all intermediaries at the same time as the OPPS system release. You must then internally test the software and share it with those providers who will use version 3051.4A.01 of the 835.

See Attachments 1, 2, and 3.

Medical Review

The methodology of review for hospital outpatient and CMHC claims does not change under the OPPS. The goal is to identify inappropriate billing for hospital outpatient and partial hospitalization services and to ensure that payment is not made for non-covered services.

* The revised OCE edits will suspend claims for medical review. All claims must pass through Level
* 1 claim edits prior to suspension via the OCE and/or medical review edits. However, the claims processing systems must assure that the suspended claim has passed through all medical review edits
* (e.g., focused and random) before the claim is reviewed. Conduct routine or complex medical review of all claims that are referred to medical review from the OCE until otherwise directed. Continue to select claims on a random basis, and focused medical review using guidelines specified in MIM §3920--Medical Review of Hospital Outpatient Claims. For random review, select a limited sample

of prepay claims that have been approved for payment by the OCE (i.e., claims that have not been denied or suspended for medical review). Since OCE does not make coverage determinations these claims must be reviewed to ensure that the services billed were reasonable and necessary.

Regarding focused medical review, establish edits which support prepayment or postpayment focused review based on the guidelines in MIM §3939, such as targeting providers with significant error rates and providers demonstrating questionable utilization patterns such as consistent upcoding of HCPCS/modifier codes. High cost drugs and devices qualifying for transitional pass-through payments as identified in the BBRA shall be included in this review as per MIM §3920.2B review guidelines. Use focused medical review strategy for the majority of your medical review workload.

Make a payment determination as to whether the billed HCPCS/modifier codes are appropriate (i.e., if the service(s) is reasonable and necessary; not excluded from coverage; furnished; and all other
* requirements for coverage are met) based on the information on the claim, paid history file, and provider solicited medical documentation. Use the following guidelines when making coverage determination:

o Determine if the billed HCPCS/modifier code meets all coverage requirements (i.e., covered), if applicable accept the claim as submitted;

o Determine if the service billed was covered but billed at an inappropriately higher level. If applicable, adjust the bill by selecting the appropriate HCPCS/modifier code that reflects the services provided to the beneficiary. The reviewer uses a system flag/indicator with the appropriate HCPCS/modifier code to indicate whether the HCPCS code or modifier or HCPCS code and modifier were changed. All changes should be reflected on the remittance advice. The system shall be able to collect and report both the original and reviewer adjudicated HCPCS/modifier billed, and the amount billed and subsequently paid. Only the new HCPCS code/modifier will be sent to CWF until October 1, 2000. After October 1, 2000 send both the denied HCPCS/modifier and the new HCPCS/modifier to CWF;

* o Determine if some of the services rendered and billed were not reasonable and necessary, and if so, deny those services. If a primary procedure is determined to be non-covered and is denied by Medical Review (MR), then the associated ancillary or component services should also be denied. If all services billed on the claim were not reasonable and necessary, deny the entire claim;

o Determine if some of the services furnished are excluded from coverage, and if so, deny those services. If a primary procedure is determined to be non-covered and is denied by MR, then the associated ancillary or component services should also be denied. If all services billed on the claims are excluded from coverage, deny the entire claim; and

o Determine if the billed HCPCS/modifier code was not furnished, and if so, deny the code and apply the fraud and abuse guidelines in MIM §3950.

For any full or partial denials made, adjust the claim accordingly to prevent or recover the overpayment. A partial denials is defined as either the disallowance of specific billed HCPCS/modifier code(s) or reclassification into a lower code. Partial denials based on classification into a new HCPCS/modifier code or full denial(s) because the services were not considered reasonable and necessary, are subject to appeal rights.

Consider particular areas of vulnerability in your data analysis and review activities (MIM §3920.2B review guidelines). Examples of vulnerable areas include:

o Incorrect coding;

o Duplicate processing of OPPS services under carrier billing;

* o Unrelated E&M procedure codes (modifier 25) with single/multiple surgeries (modifier 79);

o Billing multiple same day visits on separate claims; and

- Inappropriate use of partial hospitalization.

* The OCE will suspend Partial Hospitalization Program (PHP) claims to medical review. Use medical review guidelines found at MIM §3920.3 to review the PHP claims suspended from the OCE or other edits. Once the claim has suspended, the medical review unit should perform routine manual review in order to determine if payment for the day may be made. In the event that the determination to pay for the day cannot be made, the medical review unit must perform a complex medical review prior to denying the day. The claim determination should be made based on the medical necessity of the day and not the individual services provided on that day. However, individual partial hospitalization services that are non-covered may be line item denied. Therefore, intermediaries must review any local medical review policies (LMRP) for PHP services and modify those LMRP's accordingly.

Concerning workload, we acknowledge that there is a mid-fiscal year (FY) change in review activity. We feel that this should not significantly impact your ability to meet your remaining FY negotiated workload. The medical review workload for random and focused medical reviews are to be reported to HCFA using the current reporting mechanism. (i.e., Report of Benefit Savings, Medicare Administrative and Financial Management System, and Focused Medical Review Reports).

* Segregate MR workload, costs, and savings resulting from the reviews attributed to the OCE. The system will be able to collect and report, on a monthly basis, the total number of claims suspended to medical review, the number of claims allowed for payment after MR, and those denied (full or part, such as line item), and the dollar amount paid and those denied (in full or part). You are required to use the Outpatient Code Editor Medical Review Reporting Template to report to HCFA, on a monthly basis, the outcome information. (See attachment 4.) Collect and report using the template beginning the first starting month of OPPS medical review and continuing until further notice. Within 30 days after the close of each month, submit one copy of the report to your regional office and one copy to central office at the address below:
*
*
*
* Health Care Financing Administration
* Office of Financial Management
* Attn: Program Integrity Group
* Mail Stop: C3-02-16
* 7500 Security Boulevard
* Baltimore, Maryland 21244-1850
*
* You may send the report electronically to the central office corporate ID at OPPPSREPORTS@hcfa.gov.
*
* For claims that suspend for both regular MR and OCE MR, continue to count these claims under usual workload and associated costs and savings (not under OCE related workload, etc.). By identifying this workload you will be better able to determine the effect of the OCE and focused/random reviews on your regular medical review workload.
*
* The OCE will also edit to suspend claims for a potential noncovered service submitted for your review (condition 20). Currently, for condition code 20, the system can only suspend the entire claim for review. If you have the existing capability of MR assisted programs such as super-ops, or can use first level reviewers (e.g., routine review) to review OPPS demand bills are, you encouraged to do so. We also advocate you automate the demand bill review process (as well as other types of bills), if the review of those claims routinely result in a denial (e.g., affirmation).

Provider Notification

Please use information in this PM to notify your providers of the OPPS and the resulting changes to billing. Assure that your providers receive this bulletin prior to May 1, 2000.

* You should also notify your providers of the redlined changes to this PM.

The *implementation date* of this Program Memorandum (PM) is August 14, 2000.

The *effective date* of this PM is August 1, 2000.

Funding will be made available through the regular budget process for implementation.

This PM should be discarded after August 1, 2001.

Contractors should contact the appropriate regional office with any questions.

4 Attachments

Attachment I

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER/ NAME | PART A | PAID DATE: MM/DD/CCYY REMIT#: 1234567890 | PAGE 1

PATIENT NAME	PATIENT CNTRL#	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ
HIC#	ICN	RC	REM	OUTCD CAPCD		COVD CHGS	ESRD NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG HICHG TO RC	REM	PROF COMP		MSP PAYMT NCOVD CHGS		INTEREST	PROC CD AMT
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS		NET REIMB
123456789012345678 1 1	12345678901234567890 123	1234	123		1234567.89	1234567.89	1234567.89	1234567.89
123456789012345678	12345678901234567890 123	1234	1	1		1234567.89	1234567.89	1234567.89
12345678 12345678	12 1 123	123	1234	1234567.89	1234567.89	1234567.89	1234567.89	1234567.89
12	1234 1234 1234	123	1234	1234567.89	1234567.89	1234567.89		1234567.89
SUBTOTAL FISCAL MMCCYY					12345678.90	12345678.90	12345678.90	12345678.90
YEAR					12345678.90	12345678.90	12345678.90	12345678.90
				12345678.90	12345678.90	12345678.90	12345678.90	12345678.90
	12345 12345 12345			12345678.90	12345678.90	12345678.90		12345678.90
SUBTOTAL PART A					123456789.01	123456789.01	123456789.01	123456789.01
					123456789.01	123456789.01	123456789.01	123456789.01
				123456789.01	123456789.01	123456789.01	123456789.01	123456789.01
	123456 123456 123456			123456789.01	123456789.01	123456789.01	123456789.01	

2000 VERSION

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER / NAME | PART B | PAID DATE: MM/DD/CCYY | REMIT#: 1234567890 | PAGE 2

PATIENT NAME	PATIENT CNTRL#			RC	REM	DRG#		DRG OUT AMT		COINSURANCE	PAT REFUND	CONTRACT ADJ
HIM#	IN			RC	REM	OUTED	CAPCD			COVD CHGS	ESRD	NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG	HICHG	TO	RC	REM	PROF	COMP		MSP PAYMT	NCOVD CHGS		INTEREST	PROC CD AMT
CLM STATUS	COST	COVDY	NCOVDY	RC	REM	DRG	AMT		DEDUCTIBLES	DENIED CHGS			NET REIMB
123456789012345678 1 1	12345678901234567890			123	1234	123			1234567.89	1234567.89		1234567.89	1234567.89
123456789012345678	9	12345678901234567890		123	1234	1			1234567.89	1234567.89		1234567.89	
12345678 12345678	12	1	123	123	1234	1234567.89			1234567.89	1234567.89		1234567.89	1234567.89
12	1234	1234	1234	123	1234	1234567.89			1234567.89	1234567.89			1234567.89
SUBTOTAL FISCAL MMCCYY							12345678.90		12345678.90	12345678.90		12345678.90	
YEAR									12345678.90	12345678.90		12345678.90	12345678.90
						12345678.90			12345678.90	12345678.90		12345678.90	12345678.90
	12345	12345	12345			12345678.90			12345678.90	12345678.90			12345678.90
SUBTOTAL PART B							123456789.01	123456789.01	123456789.01	123456789.01			
								123456789.01	123456789.01	123456789.01	123456789.01		
						123456789.01	123456789.01	123456789.01	123456789.01	123456789.01			
	123456	123456	123456			123456789.01	123456789.01	123456789.01		123456789.01			

2000 VERSION

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER / NAME PAID DATE: MM/DD/CCYY REMIT#: 1234567890 PAGE 3

SUMMARY

CLAIM DATA:

DAYS:
COST: 1234567
COVDY: 1234567
NCOVDY: 1234567

CHARGES:
COVD: 12,345,678.90
NCOVD: 12,345,678.90
DENIED: 12,345,678.90

PROF COMP: 12,345,678.90
MSP PAYMT: 12,345,678.90
DEDUCTIBLES: 12,345,678.90
COINSURANCE: 12,345,678.90
PAT REFUND: 12,345,678.90

INTEREST: 12,345,678.90
CONTRACT ADJ: 12,345,678.90
PROC CD AMT: 12,345,678.90
NET REIMB: 12,345,678.90

PASS THRU AMOUNTS:
CAPITAL: 123,456,789.01
RETURN ON EQUITY: 123,456,789.01
DIRECT MEDICAL EDUCATION: 123,456,789.01
KIDNEY ACQUISITION: 123,456,789.01
BAD DEBT: 123,456,789.01
NON-PHYSICIAN ANESTHETISTS: 123,456,789.01
TOTAL PASS THRU: 123,456,789.01
HEMOPHILIA ADD ON: 123,456,789.01
PIP PAYMENT: 123,456,789.01
SETTLEMENT PAYMENTS: 123,456,789.01
ACCELERATED PAYMENTS: 123,456,789.01
REFUNDS: 123,456,789.01
PENALTY RELEASE: 123,456,789.01
TRANS OUTP PYMT: 123,456,789.01

WITHHOLD FROM PAYMENTS:

CLAIM ACCOUNTS RECEIVABLE: 123,456,789.01
ACCELERATED PAYMENTS: 123,456,789.01
PENALTY: 123,456,789.01
SETTLEMENT: 123,456,789.01
TOTAL WITHHOLD 123,456,789.01

PROVIDER PAYMENT RECAP:

PAYMENTS:
DRG OUT AMT: 123,456,789.01
INTEREST: 123,456,789.01
PROC CD AMT: 123,456,789.01
NET REIMB: 123,456,789.01
TOTAL PASS THRU: 123,456,789.01
PIP PAYMENTS: 123,456,789.01
SETTLEMENT PYMTS: 123,456,789.01
ACCELERATED PYMTS: 123,456,789.01
REFUNDS: 123,456,789.01
PENALTY RELEASE: 123,456,789.01
TRANS OUTP PYMT: 123,456,789.01
HEMOPHILIA ADD ON: 123,456,789.01

WITHHOLD: 123,456,789.01

NET PROVIDER PAYMENT: 123,456,789.01
(PAYMENTS MINUS WITHHOLD)

CHECK / EFT NUMBER: 1234567890

2000 VERSION

Changes in SPR 2000 Version from the Prior Version

1. Reference to HCPCS changed to procedure code as other code sets such as the national drug code (NDC) may begin to be used in addition to HCPCS in the future.

2. Separate SPR reporting of the DRG operating amount and the DRG capital amount stopped. A combined operating and capital amount will now be reported on the SPR to correspond to 835 reporting.

3. A summary data element has been added for the transitional outpatient payment, a quarterly provider payment that will be issued as warranted to supplement line item payments for services paid under OPPS.

4. Date fields have been expanded to enable reporting of the century.

Attachment 2

MEDICARE STANDARD PAPER REMITTANCE (SPR) ADVICE
DATA DIRECTORY AND 835 MAP

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Intermediary name/ address/city/state/ zip/phone number	as written	AN 132 characters	Name=1-080.A-N102 Other data elements (DE) are fiscal intermediary (FI) generated.
Provider number	as written	AN 13	1-080.B-N104
Provider name	as written	AN 25	1-080.B-N102
Literal Value: Part A	as written	AN 06	Determined by bill e.c type in 2-005-TS302
Literal Value: Part B	as written	AN 06	
Paid date	as written	N MM/DD/CCYY	1-020-BPR16
Remittance advice	REMIT	N 9(l 0)	Fl generated.
Literal Value: Page	as written	AN 06	Fl generated.
Pages 1&2			
Patient Last Name	PATIENT NAME	AN 18	2-030.A-NM103
Patient First Name		AN 01	2-030.A-NM104
Patient Mid. Initial		AN 01	2-030.A-NM105
Health insurance claim number	HIM#	AN 19	2-030.A-NM109
Statement covers period--start	FROM DT	N MMDDCCYY	2-050.A-DTM02
Statement covers period--end	THRU DT	N MMDDCCYY	2-050.B-DTM02
Claim status code	CLM STATUS	AN02	2-010-CLP02
Patient control #	PATIENT CNTRL #	AN 20	2-010-CLP01
Internal control #	IN	AN 23	2-010-CLP07
Patient name change	NACHG	AN 02	2-030.A-NM101 if 74
HIM change	HICHG	AN 01	2-030.A-NM108 if C

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Type of bill	TO	AN 03	2-010-CLP08
Cost report days	COST	N S9(3)	2-033-MIA15
Covered days/ visits	COVDY	N S9(3)	2-064-QTY02 when CA in prior DE
Noncovered days	NCOVDY	N S9(3)	2-064-QTY02 when NA in prior DE
Reason code (4 occurrences)	RC	AN 05	2-020-CAS02, 05,08 and 11
Remark code (4 occurrences)	REM	AN 05	Inpatient: 2-033-MIA -05, 20, 21, 22 Outpatient: 2-035-MOA03, 04, 05, 06
DRG #	as written	N 9(3)	2-010-CLP1 1
Outlier code	OUTED	AN 02	2-062-AMT01 if ZZ
Capital code	CAPCD	AN 01	2-033-MIA08
Professional component	PROF COMP	N S9(7).99	Total of amounts in 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when 89 in prior DE
DRG operating and capital amount	DRG AMT	N S9(7).99	2-033-MIA04
DRG outlier amount	DRG OUT	AMT N S9(7).99	2-062-AMT02 when ZZ in prior DE
MSP primary	MSP PAYMT	N S9(7).99	2-062-AMT02 amount when NJ in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of 2-020 Or 2-090 CAS03, 06, 09, 12, 15 or 18 when and/ or 66 in prior DE
Coinsurance amount	COINSURANCE	N S9(7).99	Total of 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when 2 in prior DE
Covered charges	COVD CHGS	N S9(7).99	2-060-AMT02 when AU in prior DE
Noncovered charges	NCOVD CHGS	N S9(7).99	2-010-CLP03 minus 2-060-AMT02 when AU in prior DE
Denied charges	DENIED CHGS	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09, 12, 15 or 18
Patient refund	PAT REFUND	N S9(7).99	2-020 or 2-amount 090-CAS 03, 06, 09, 12, 15 or 18 when 100 in prior DE
Claim ESRD	ESRD NET ADJ	N S9(7).99	2-020 or 2-reduction 090-CAS 03, 06, 09, 12, 15 or 18 when 118 in prior DE
Interest	INTEREST	N S9(6).99	2-060-AMT02 when in prior DE
Contractual	CONTRACT ADJ	N S9(7).99	Total of 2-020 adjustment or 2-090 CAS03, 06, 09, 12, 15 and 17 when CO in CASOI
Per Diem rate	PER DIEM RTE	N S9(7).99	2-062-AMT02 when DY in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION

Procedure code amount	PROC CD AMT	N S9(7).99	2-035-MOA02
Net reimbursement	NET REIMB	N S9(7).99	2-010-CLP04

Page 3

Claim Data			
Cost report days	DAYS COST	N S9(3)	Total of claim level SPR COST.
Covered days/visits	DAYS COVDY	N S9(4)	Total of claim level SPR COVDY.
Noncovered days	DAYS NCOVDY	N S9(4)	Total of claim level SPR NCOVDY.
Covered charges	CHARGES COVD	N S9(7).99	Total of claim level SPR COVD CHGS.
Noncovered charges	CHARGES NCOVD	N S9(7).99	Total of claim level SPR NCOVD CHGS.
Denied charges	CHARGES DENIED	N S9(7).99	Total of claim level SPR DENIED CHGS.
Professional component	PROF COMP	N S9(7).99	Total of claim level SPR PROF COMP.
MSP primary	MSP PAYMT	N S9(7).99	Total of claim amount level SPR MSP PAYMT.
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of claim level SPR DEDUCTIBLES.
Coinsurance amount	COINSURANCE	N S9(7).99	Total of claim level SPR COINSURANCE.

Full Description	SPR ID	SPR FIELD SIZE	835 LOCATION

(In order of appearance)		CHARACTERISTICS	
Patient refund	PAT REFUND	N S9(7).99	Total of claim amount level SPR PAT REFUND.
Interest	INTEREST	N S9(7).99	Total of claim level SPR INTEREST.
Contractual adjustment	CONTRACT ADJ	N S9(7).99	Total of claim level SPR CONTRACT ADJ.
Procedure code payable amount	PROC CD AMT	N S9(7).99	Total of claim level SPR PROC CD AMT.
Claim payment amount	NET REIMB	N S9(7).99	Total of claim level SPR NET REIMB.
Summary Data Pass Thru amounts			3-010-PLB04, 06, 08 or 10 when:
Capital pass thru	CAPITAL	N S9(7).99	... CP in prior DE
Return on equity	as written	N S9(7).99	...RE in prior DE
Direct medical education	as written	N S9(7).99	... DM in prior DE
Kidney acquisition	as written	N S9(7).99	...KA in prior DE
Bad debt	as written	N S9(7).99	...BD in prior DE
Non-physician anesthetists	as written	N S9(7).99	...CR in prior DE
Hemophilia add on	as written	N S9(7).99	... ZZ in prior DE
Total pass thru	as written	N S9(7).99	Total of the above pass thru amounts.
Non-Pass Thru Amounts			3-010-PLB04, 06, 08 or 10 when:
PIP payment	as written	N S9(7).99	... PP in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Settlement amounts	SETTLEMENT PAYMENTS	N S9(7).99	... FP in prior DE

Accelerated payments	as written	N S9(7).99	... AP in prior DE
Refunds	as written	N S9(7).99	...RF in prior DE
Penalty release	as written	N S9(7).99	...RS in prior DE
Transitional outpatient payment	TRANS OP PYMT	N S9(7).99	... IR in prior DE
Withhold from Payment			3-010-PLB04, 06, 08 or 10 when:
Claims accounts receivable	as written	N S9(7).99	... AA in prior DE
Accelerated payments	as written	N S9(7).99	...AW in prior DE
Penalty	as written	N S9(7).99	...PW in prior DE
Settlement	as written	N S9(7).99	... OR in prior DE
Total withholding	TOTAL WTHLD	N S9(7).99	Total of the above withholding amounts.
Provider Payment Recap			
Payments and withhold previously listed			
Net provider payment	as written	N S9(7).99	1-020-BPR02
Check/EFT number	as written	AN 10	1-040-TRN02

See 835 implementation guides for data element definitions, completion and use.

AMT02	**0782**	Monetary Amount	
R 1	15 M	**Total Covered Charges**	**AU=43-10**
		Per Diem Amount (Inpatient and Partial Hospitalization Only)	**DY=22-09**
		Patient Paid Amount	**F5=23-04**
		Interest Amount	**I=40-03**
		MSP Liability Amount Met	**NJ=42-11**
		Negative Reimbursement	**NL=22-08**
		Hemophilia Add-on Amount	**ZK=22-10**
		Outlier Amount	**ZZ=42-04**
AMT03	0478	Credit/Debit Flag Code	
		Not Used	

X12 Segment Name: **REF** Reference Numbers
Name: **ASC, APC or HIPPS Group Number**
Loop: SVC
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Purpose: **To provide the Ambulatory Surgical Center (ASC), Ambulatory Patient Code (APC), or the home Health Insurance Prospective Payment System (HIPPS) code assigned to this service.**
Usage: **Conditional**
Example: **REF*1S*1~**
Comments: **The ASC and APC numbers are generated by the Medicare PRICER program. The HIPPS number is submitted on the claim. The applicable number must be reported for a Medicare service paid under the ASC, outpatient PPS or a home health PPS payment methodology.**

Syntax Note: 0203 - At least one of REF02 or REF03 must be present

Element Attributes		Data Element Usage	**Flat File Map**
REF01 ID 2	0128 3 M	Reference Number Qualifier Code qualifying the Reference number Codes: **1S Ambulatory Patient Group (APG) Number**	Translator Generated (TG)
REF02 AN 1	0127 30 M	Reference Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. **ASC, APC or home health HIPPS Number**	**30-15 ASC** FISS to furnish APC & HH HIPPS # maps

* **NOTE:** **Pricer supplies the APC only for a single HCPCS included in that APC. No**
* **APC is generated for the other HCPCS included in that APC.**
*

REF03	0352	Description **Not Used**	

3

X12 Segment Name: **REF** Reference Numbers

Name: **ASC or HIPPS Rate (percent)**
Loop: SVC
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Purpose: **To convey the ASC or the home Health Insurance Prospective Payment System (HIPPS) percentage rate.**
Usage: **Conditional**
Example: **Ref*RB*100~**
Comments: **This segment must be sent for Medicare ASC and home health HIPPS claims.**

Syntax Note: 0203 - At least one of REF02 or REF03 must be present

Element Attributes		Data Element Usage	**Flat File Map**
REF01	0128	Reference Number Qualifier	Translator
ID 2	3 M	Code qualifying the Reference number Codes: **RB Rate Code Number**	Generated (TG)
REF02	0127	Reference Number	**30-16 ASC**
AN 1	30 M	Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. **ASC or home health HIPPS Rate (percent)** ASC Codes: HIPPS Codes: **0 Zero percent** **0 Zero percent** **50 50 percent** **50 50 percent** **100 100 percent** **60 60 percent** **150 150 percent** **100 100 percent**	FISS to furnish HIPPS rate map
REF03	0352	Description **Not Used**	

4

X12 Segment Name: **AMT** Monetary Amount

Name: **ASC, APC or HIPPS Priced Amount**
Loop: SVC
Max. Use: 1
X12 Purpose: To indicate the total monetary amount.
Purpose: **To convey the ASC, APC, or HIPPS priced amount (the allowed amount) generated by PRICER.**
Usage: **Conditional**
Example: **AMT*B6*467~**
Comments: **This segment must be sent on Medicare ASC and APC remittances, and on remittances for home health HIPPS sent at the end of a 60-day benefit period. (Do not report for the payment at the beginning of a home health HIPPS 60-day benefit period.)**

Element Attributes		Data Element Usage	**Flat File Map**
AMT01	0522	Amount Qualifier Code	Translator
ID 1 2 M		Code to qualify amount: Codes: **B6 Allowed Amount - Actual Amount**	Generated (TG)
AMT02	0782	Monetary Amount	**30-17 APC** (when
R 1	15 M	**ASC, APC or home health HIPPS priced amount**	entries in 30-15 and 30-16) FISS to furnish the APC and HIPPS maps
AMT03	0478	Credit/Debit Flag Code **Not Used**	

5

STANDARD PROVIDER LEVEL ADJUSTMENT (PLB) REASON CODES

The PLB segment carries provider level financial adjustment data which is not related to the adjustment data for the claims addressed in a specific 835 transaction. As with the CAS financial adjustment segments, positive numbers in monetary amount elements have a negative arithmetic value in the balancing routines, while negative numbers have a positive arithmetic value in the balancing routines.

PLB Code Value	Message
AA	Receivable today
AW	Accelerated payment withholding
AP	Accelerated payment amount
BD	Bad debt pass-thru amount
BF	Balance forward; a negative balance to be carrier forward and applied in a subsequent billing cycle.
BN	Bonus; used to report a Medicare Transitional Outpatient PPS payment.
CA	Manual claims adjustment; approved claims payments calculated outside normal processing.
CO	Carryover; a negative balance amount which has been carried forward from a previous billing cycle and applied in the current billing cycle.
CP	Capital pass-thru amount
CR	Nurse anesthetist pass-thru amount (CRNA)
CW	Claim withholding
CX	Total cancel claim amount
DM	Direct medical education pass-thru amount
DS	Disproportionate share amount
FS	Final settlement amount (cost report)
GM	Graduate medical education pass-thru amount
IM	Indirect medical education pass-thru amount
IN	Interest paid
IP	Interest assessed on late-filed cost reports and/or delinquent refunds
IR	Interim rate lump sum adjustment
KA	Organ acquisition pass-thru amount
LR	Late cost report penalty amount
NP	Non-physician pass-thru amount
OA	Part A offset for affiliated provider
OB	Part B offset for affiliated provider

PLB Code Value	Message
OR	Overpayment recovery; overpayment amount not fully satisfied in prior cycles.
OS	Outside recovery; money withheld for external organizations, e.g., IRS
PA	Adjustment for claims paid after PIP effective date. (This amount must be multiplied by negative 1 [-1].)
PL	PIP lump sum adjustment
PO	Other pass-thru amount
PP	PIP payment
PR	Provider refund adjustment (To be used for credit balance reconciliation.)
PS	Pass-thru lump sum adjustment
PW	Penalty withholding
RA	Check received from the provider for credit balancing for Part A amounts due.
RB	Check received from the provider for credit balancing for Part B amounts due.
RE	Return on equity
RF	Refunds
RI	Reissued check amount
RS	Penalty release amount
SW	Penalty withhold amount
TR	Retroactive adjustment (cost report)
TS	Tentative settlement (cost report)